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» 1	of the State of California JOEL S. PRIMES, Supervising		
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8	BOARD OF PODIATRIC MEDICINE MEDICAL BOARD OF CALIFORNIA		
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10	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA		
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12	In the Matter of the Accusation) No. D-4280 Against:		
13)) <u>ACCUSATION</u>		
14	BRADLEY G. BENSON, D.P.M.) 875 East Canal Drive, #10)		
15	Turlock, CA 95380		
16	License No. E-2937		
17	Respondent.		
18	JAMES H. RATHLESBERGER, for causes for discipline,		
19	alleges:		
20	1. Complainant James H. Rathlesberger makes and files		
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	this accusation in his official capacity as Executive Officer of		
22	the Board of Podiatric Medicine, Medical Board of California,		
23	(hereinafter referred to as "Board").		
24	2. On June 7, 1982, the Board issued license number		
25	E-2937 to Bradley G. Benson, D.P.M. (hereinafter referred to as		
26	"respondent"). The license is current and in good standing with		
27	an expiration date of April 30, 1990.		

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3. Under Business and Professions Code section 2234, the Board shall take action against the holder of a license to practice podiatric medicine who is guilty of unprofessional conduct which includes:

- (b) Gross Negligence
- (d) Incompetence
- 4. Business and Professions Code section 2497 provides:
 - "(a) The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222.
 - "(b) The board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative law judge who presided at the hearing shall be present during the board's consideration of the case and shall assist and advise the board.
- 5. Business and Professions Code section 2497.5 provides:
 - "(a) The board may request the administrative law judge, under his or her proposed decision in resolution of a

disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

- "(b) The costs to be assessed shall be fixed by the administrative law judge and shall not in any event be increased by the board. When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.
- "(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment by bringing an action in any appropriate court . . This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.
- "(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.
- "(e)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.
- "(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who

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demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year period for those unpaid costs.

- "(f) All costs recovered under this section shall be deposited in the Podiatry Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.
- 6. Respondent has subjected his license to discipline under Business and Professions Code section 2234 on the grounds of unprofessional conduct as defined by subsections (b) Gross Negligence and (d) Incompetence as if more specifically set forth below:

Respondent was grossly negligent and incompetent in his evaluation, diagnosis, care, treatment, and 1984 surgery performed on patient Aileen R.

On September 6, 1984, 63 year old female patient Aileen R. underwent surgery at Oak Valley Hospital, Oakdale, CA performed by respondent for removal of neuromas of the third inter-space bilaterally and the second inter-space of her left foot. Surgery was completed on an out-patient basis with no complications at the time of surgery. Patient Aileen R. was released to her home with respondent making numerous home visits.

In the ensuing postoperative course patient Aileen R. developed gangrene of the third digit left foot with subsequent amputation of the third digit left foot on October 4, 1984. The amputation was performed by H. M. Goodman, M.D. at Doctors Hospital, Modesto. This amputation failed to heal appropriately.

She developed further necrosis which eventually led to a transmetatarsal amputation of her left foot on November 8, 1984. This surgery was performed by Rodney Cornelsen, M.D. at Doctors Hospital, Modesto.

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Patient Aileen R. had a well-documented history of peripheral vascular disease. A femoral populate bypass surgery was performed bilaterally in 1976 and again in 1977.

The most recent vascular workup was in 1980 for which patient Aileen R. underwent arteriography to the lower extremities revealing further progression of the vascular disease.

Respondent visited patient Aileen R. at her home. postoperative course was essentially uneventful until September 17, 1984. At that time respondent noted mild maceration in the distal aspect of the incisions of the third interspace bilaterally. On September 20, 1984, respondent noted significant tenderness in the Achilles' tendon and anterior tendons of the ankle. On September 27, 1984, respondent recognized a bacterial infection and that the incision was not completely closed. October 1, 1984, respondent noted that the third toe was dark purple in color. On October 4, 1984, patient Aileen R. was taken to Memorial North Hospital to a cardio-vascular lab for a segmental doppler pressure evaluation of the left lower The results revealed an ankle-arm index of 0.45. This was to the left foot. There were no arterial sounds to the third digit; the fourth and second digits' signals could be obtained. On October 4, 1984, Dr. Goodman amputated the third

toe of the left foot. The amputation site granulated somewhat and a split-thickness skin graft was performed to cover the wound; however, the operative site had become infected and further necrosis was evident to the second digit as well as the plantar aspect of the first digit. The patient then underwent a transmetatarsal amputation.

Respondent was grossly negligent and incompetent in his care and treatment of patient Aileen R. as is more specifically set forth below:

A.

FAILURE TO PROPERLY EVALUATE PATIENT PREOPERATIVELY

1. Respondent failed to adequately perform a preoperative evaluation of patient Aileen R. The past medical history respondent took was totally inadequate and failed to adequately disclose the nature of the vascular surgery which occurred in 1976 and 1977 as well as the repeat evaluation with arteriogram in 1980.

If a proper preoperative evaluation were performed the severe peripheral vascular disease would have been recognized and this patient would not have been considered a proper surgical candidate.

Respondent failed to recognize the significant vascular disease in this patient. The failure to diagnose this

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significant vascular problem placed patient Aileen R. in a position where her limbs were at significant risk.

B.

FAILURE IN MANAGEMENT OF POSTOPERATIVE INFECTION

Respondent's failure to promptly diagnose and properly treat this postoperative wound infection constitutes gross negligence and incompetence.

Respondent failed to obtain a wound culture which would have identified the organisms present in the wound and permitted selection of the proper antibiotic. Respondent's failure to promptly recognize the postoperative wound infection and to properly treat this infection placed patient Aileen R's limb and life at serious risk.

FAILURE TO PROMPTLY DIAGNOSE AND INITIATE TREATMENT OF THE VASCULAR COMPLICATION

Respondent finally recognized the compromised circulation to the third toe but allowed it to continue and progress without offering any specific treatment other than observation until the toe was no longer salvageable. The patient expressed concern on several occasions that the circulation was severely compromised to the toe. Only when wet gangrene was fully developed and the toe was entirely gangrenous did respondent initiate a diagnostic work-up. This diagnosis came too late. Respondent failed to recognize and differentiate normal circulation versus partially impaired circulation versus

total tissue necrosis on patient Aileen R's foot. Respondent 1 failed to recognize the need for prompt vascular intervention 2 3 when circulatory compromise was recognized. 4 WHEREFORE, complainant prays that a hearing be had and that the Board make its order: 5 Revoking or suspending License Number E-2937, 6 7 issued to respondent Bradley G. Benson, D.P.M. 8 Recovery of actual and reasonable costs of the 9 investigation and prosecution of this case. 10 Taking such other and further action as may be 11 deemed proper and appropriate. 12 DATED: June 20, 1990 13 14 15 Executive Officer Board of Podiatric Medicine 16 Medical Board of California Department of Consumer Affairs 17 State of California 18 Complainant 19 03576110SA90AD0960 20 JSP:hf 21 22 23 24 25 26 27